STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013335	A. BUILDING **01** B. WING _____	**03/17/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON'S CROSSINGS HEALTH CAMPUS	**395 8TH AVENUE** **TERRE HAUTE, IN 47804**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS An Initial Life Safety Code Certification and State Licensure Survey for a facility with 62 SNF beds, 10 SNF/NF beds and 30 Residential beds was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 03/17/15 Facility Number: 013335 Provider Number: 013335 AIM Number: NA Surveyor: Bridget Brown, Life Safety Code Specialist At this Initial Life Safety Code and Environmental survey, the portion of Harrison's Crossings Health Campus which will be certified was found in compliance with Requirements for Participation in Medicare, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2-3.1-19, Environment and Physical Standards of the Indiana Health Facilities Rules for Comprehensive care facilities. The residential area was found in compliance with 410 IAC 16.2-5-1.5, Sanitation and Safety Standards and 16-2-5-1.6, Physical Plant Standards of the Indiana Health Facilities Rules for Residential care facilities. This facility located on the first floor of a two story building was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with hard wired smoke	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013335	A. BUILDING **01** B. WING _____	**03/17/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON'S CROSSINGS HEALTH CAMPUS	**395 8TH AVENUE** **TERRE HAUTE, IN 47804**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 detection in corridors, in spaces open to the corridor and in resident rooms. The certified beds are located on the first floor. The facility had a cetified capacity for 72 with a census of 0 at the time of this survey. All areas accessible to residents and all areas providing facility services were sprinklered. Quality Review by Dennis Austill, Life Safety Code Specialist on 03/19/15.	K 000		